VERMONT
DEPARTMENT OF HEALTH

Vermont Immunization Program
Provider Profile and Enrollment in the Vaccines for Children (VFC) and/or the Vaccines for Adults (VFA) Program

Please check one box:

- ☐ **Vaccines for Children Program**
- ☐ **Vaccines for Adults Program**
- ☐ **Vaccines for Children & Vaccines for Adults Program**

Physician-In-Charge: _____

Vermont Medical License Number _____

Name of Practice: _____ **Practice PIN Number** _____

Contact Person: _____

Email Address: _____

Telephone Number: _____ **Fax Number:** _____

Physical Street Address: _____

Mailing Address: □ Check here if mailing address is the same as above

_____

Type of Facility:

- □ A. Public Health Department
- □ B. Public Hospital
- □ C. Private Practice (Individual or Group)
- □ D. Federally Qualified/ Rural Health Center
- □ E. Private Hospital
- □ F. Other Facility

Profit ☐

Non-profit ☐ If your organization is non-profit as defined by Section 501(c)(3) of the Internal Revenue Service Tax Code, please check this box.

If unsure of your tax status please consult your auditor or business manager.

Immunization Data:

Part A.

NOTE: The following information is used to determine the amount of vaccine needed for your practice and **MUST be based on actual data,** not estimates.

DATA SOURCE: _____

Based on the data source listed above, below is the projected number of children who will receive vaccinations at your health care facility by age group for a 12 month period beginning July 1, 2010.

<1 Year	1-6 Years	7-18 Years	Total Number of Children

For adult patients

≥ 19 Years	Total Number of Adults

If you only offer immunization services to adults do not fill out part B.

Part B. **Take the number of children above and indicate the number of who are expected to be VFC eligible, by category and age group below.**

*** Underinsured: Only a FQHC or RHC should complete the Underinsured row.

	< 1 Year	1 – 6 Years	7 – 18 Years	Total
Enrolled in Medicaid				
No Health Insurance				
Amer. Indian/Alaskan Native				
***** Underinsured (Only FQHC/RHC)**				
Total				

Provider Agreement to Enroll in the Vaccines For Children (VFC) and/or Vaccine For Adults (VFA) Program

The Vermont Department of Health Immunization Program receives funding for vaccines from the Federal grant "Immunizations and VFC" grant H23CH1222529, CFDA # 93.268. In order to participate in the Vermont Department of Health (VDH) Vaccines For Children (VFC) &/or the Vaccines for Adults (VFA) Program, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated with this provider office.

1. I will screen patients (≤ 18 years of age) for VFC Program eligibility and document who qualifies under one or more of the following categories:
    a) Is an American Indian or Alaskan Native
    b) Is enrolled in Medicaid (or qualified through a State Medicaid waiver)
    c) Has no health insurance
    d) Has health insurance that does not pay for the vaccine (only applicable to FQHC or RHC)

    ~~And/or~~

    ~~I will screen patients (19 years of age and older) for the VFA program eligibility by assuring that the patient is a Vermont resident.~~
2. I will maintain all records related to VFC & VFA program for a minimum of three years and make these records available to public health officials including VDH or the Department of Health and Human Services (DHHS) upon request.
3. I will permit visits to my facility by authorized representatives of VDH Immunization Program to review compliance with VFC and/or VFA Program requirements including vaccine storage and record-keeping.
4. I will comply with and administer vaccines according to the appropriate immunization schedule, dosage, and contraindications that are established by the Advisory Committee on Immunization Practices (ACIP), and included in VFC and/or VFA Programs except if the following applies:
    a) In my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate

    <u>OR</u>

    b) The particular requirement contradicts Vermont law pertaining to religious and other exemptions.
5. I will distribute the most current Vaccine Information Statements (VIS) each time a vaccine is administered and maintain records in accordance with the National Childhood Vaccine Injury Act (NCVIA). This includes reporting clinically significant adverse events to the Vaccine Adverse Events Reporting System (VAERS).
6. I will not impose a charge for the cost of the vaccine provided to my practice through federal and state funding.
7. I will not impose a charge for the administration of the vaccine to the non-Medicaid, VFC eligible child that is higher than the maximum fee in Vermont of $13.86 established by the federal government. I will accept reimbursement for immunization administration set by the state Medicaid agency. I will not deny administration of a federally purchased vaccine to a child because the child's parent/guardian/individual of record is unable to pay the administration fee.
8. I will comply with the following requirements for ordering, proper storage, handling and accountability of vaccine.
    a) I will designate personnel to be responsible for vaccine.
    b) Vaccine personnel will develop vaccine storage and handling plan for my practice site, or use VDH template plan.

c) My practice will have appropriate equipment that can store vaccine and maintain proper conditions. Two types of storage units are acceptable: 1. a refrigerator that has a separate freezer compartment with a separate exterior doors or; 2. stand alone refrigerator and freezers.
d) My practice will use a certified, calibrated thermometer in the vaccine storage units. Refrigerator and freezer temperatures MUST be logged twice a day (once in the AM and once in the PM). Refrigerator temperatures are required to be (2° – 8° C) or (35° – 46° F) and freezer temperatures are required to be (5° F or colder) or (-15° C or colder). Any out of range temperatures MUST be reported to the Immunization Program immediately. Please call 1-802-863-7638.
e) My practice will follow proper vaccine storage practices (e.g. rotation of vaccine stock, correct vaccine placement in refrigerator unit).
f) I will report vaccine usage, waste, current inventory, and expiration dates on the Vaccine Accountability Sheets. I will notify the Immunization Program if vaccine expires, is wasted or is exposed to out-of-range temperatures.
g) I agree that all healthcare personnel in my practice who need to have a license to work in their profession, will have an active license in the State of Vermont.
h) I agree to operate in a manner intended to avoid fraud and abuse.
i) I understand that my responsibility for proper storage and handling of vaccine begins when delivery is accepted. I will check vaccine temperature monitors and take action if cold chain monitor was activated.
j) My practice site will correctly prepare and administer vaccines
k) My practice will conduct a monthly inventory to monitor vaccine use and will order vaccine on the schedule determined by VDH in accordance with vaccine need and federal and state guidance.
l) Vaccine security and equipment maintenance will be performed by my practice site.
m) Should my staff, representative, or I access VTrckS, I agree to be bound by CDC's terms of use for interacting with the online ordering system. I further agree to be bound by any applicable federal laws, regulations or guidelines related to accessing a CDC system and ordering publically funded vaccines.
n) In advance of any VTrckS access by my staff, representative or myself, I will identify each member of my staff or representative who is authorized to order vaccines on my behalf. In addition, I will maintain a record of each staff member who is authorized to order vaccines on my behalf. If changes occur, I will inform CDC within 24 hours of any change in status of current staff members or representatives who are no longer authorized to order vaccines, or the addition of any new staff authorized to order on my behalf. I certify that my identification is represented correctly on this provider enrollment form.
o) I will cooperate with VDH to recall patients if doses were mishandled or administered incorrectly.

- If there is mishandled vaccine, the Immunization Program will make every effort to work with the clinic in question to address the administration of mishandled vaccine, balancing clinic needs, cost to parents, providers and health plans, risk of illnesses or outbreaks, and overall affect on public health.
- General recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP) recommendations that define and designate proper vaccine storage and handling will be followed. IF doses administered are of questionable potency, these doses should not be counted as valid and should be repeated.
- The VDH may offer limited resources, as available, to assist with recalls and revaccination.
- If a clinic declines to recall patients who received questionable doses, VDH may request a list of affected patients and, in conjunction with the local health department, may conduct its own recall of these patients, in which case the clinic may be billed for the mishandled vaccine.
- If a clinic declines to provide a list of affected patients, VDH may issue a community notice alerting patients that they have received a potentially non-viable dose of vaccine at this clinic, and encourage these patients to contact the local health department to explore revaccination.

- Recognizing the diversity of potential storage and handling issues that may arise, the Immunization Program reserves the right to manage all cases of mishandled vaccine on a case-by-case basis, while adhering to the above guidelines.

p) I understand that failure to store and handle vaccines properly may result in a liability for mishandled/wasted doses to be replaced by the practice on a dose for dose basis.

9. I will renew enrollment annually.
10. I understand that Immunization Program may terminate this agreement at any time for failure to comply with these requirements or I may terminate this agreement at any time for personal reasons. If I terminate this agreement, I will properly return any unused vaccine purchased with federal or state funding.

Signature of Physician-In-Charge	**Print Name of Physician-In-Charge**	**Date**

Additional Providers within the Practice

Please print or type the names and medical license numbers of all health care providers in your practice (attach copies of the Additional Providers within the Practice sheet if additional space is needed).

Last Name, First, MI (Provider must have prescription writing privileges)	Medical License Number	Title (MD, DO, DN, NP, PA)
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This record is to be **submitted via mail** to and kept on file at the Vermont Department of Health Immunization Program. For questions call 802-863-7638.

VERMONT DEPARTMENT OF HEALTH
IMMUNIZATION PROGRAM
P.O. BOX 70
108 CHERRY STREET
BURLINGTON, VT 05402

Provider Agreement and Guidelines for Varicella Vaccine

For VFC enrolling practices only

ELIGIBLITY: The Vermont Department of Health Immunization Program provides varicella vaccine for children ages 12 months through 18 years.

STORAGE REQUIREMENTS: If you wish to receive varicella vaccine you will have to complete this signed agreement showing that your practice meets the following guidelines for proper storage and handing.

a) Merck & Company, Inc. the manufacturer of VARIVAX will pack and ship varicella vaccine with dry ice directly to the provider office after receiving an order from CDC, which is submitted by the Immunization Program.

b) Varicella vaccine **MUST** be stored in a freezer, and **MUST** maintain temperatures at or below -15° C (+5° F).

c) The freezer **MUST** have a separate door from the refrigerator, (e.g. regular household refrigerator). Dorm-style or larger refrigerator/freezer combinations where the freezer is within the refrigerator is **NOT** acceptable.

d) Freezer temperatures must be recorded twice a day and any out of range temperatures **MUST** be reported to the Immunization Program immediately. Please call 1-802-863-7638.

e) State-Supplied varicella vaccine cannot be moved or redistributed from the provider site that received it.

Practice Name: _____

Contact Name: _____
(Office Vaccine Manager)

Contact Telephone Number: _____

I agree to the additional conditions herein for the storage, handling and use of varicella vaccine.

_____	_____	_____
Signature of Physician-In-Charge	**Print Name of Physician-In-Charge**	**Date**